Agency
Dysphagia: Documentation Review

Resident:_____
(last) (first)

Dysphagia Plan Date:_____

Documents Reviewed:_____

1. Are daily triggers being tracked? Yes_____ No_____

2. Are triggers signed off by Nursing on the flow chart? Yes_____ No_____

3. If triggers are noted, is documentation present in the Nursing Notes? Yes_____ No_____

4. Do triggers remain appropriate for client? Yes_____ No_____

5. Are monitors up to date? Yes_____ No_____

Medication Changes: Yes_____ No_____
(since last review per nursing summary) _____
_____
_____

Diet Changes: Yes_____ No_____
(since last review)) If yes, specify _____
_____

Fluctuation in general health: Yes_____ No_____
(please specify) _____
_____

What level of dysphagia risk is the individual?_____

Hospital Visits (since last review) Yes_____ No_____
(if yes, please specify) _____
_____
_____

New Diagnosis: Yes_____ No_____
(since last review) _____
_____
_____

Other Comments: _____
_____

If the answer is "NO" to questions 1-5
Is there a plan in place that addresses these issues? Yes_____ No_____

PLANS ADDRESSING ISSUES:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Reviewers:_____ Date:_____
_____
_____
_____
_____

SE Indiana Outreach Services
J. Bailey CCC-SLP
Revised:
3-7-06